BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOSEPH R. VOLK, M.D.** Holder of License No. 13382 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-05-0504C **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Joseph R. Volk, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

JOSEPH R. VOLK, M.D.

DATED: 1-29-07

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 13382 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0504C after receiving notification of a malpractice settlement involving Respondent's care and treatment of a fifty year-old female patient ("LO").

4. At 9:00 a.m. on November 11, 1998 LO presented to the emergency room complaining of nausea, vomiting and diarrhea of several days. The emergency room physician examined LO and ordered laboratory tests showing low platelets of 5,000 and fragmented cells, indicating anemia and red cell destruction; ordered a blood transfusion; and admitted LO to the care of an internal medicine physician ("Internist") with a diagnosis of thrombocytopenia and hemolytic anemia.

5. At 5:00 p.m. Internist examined LO, considered a diagnosis of thrombotic thrombocytopenia purpura (TTP) and ordered a platelet transfusion and a hematology consultation "today". At approximately 10:10 p.m. the nurse telephoned the on call hematologist in a group practice who did not present to the hospital, but ordered laboratory tests done in the morning. The on call hematologist scheduled Respondent to evaluate LO the next day.

6. On November 12, 1998 at 10:00 a.m. Respondent saw LO, but did not examine her or order laboratory tests. At 6:00 p.m. Respondent returned and reviewed LO's history, laboratory tests and the physical examination Internist conducted the day before. Respondent noted LO was "mentally slow" and "ill". Respondent diagnosed LO with thrombotic thrombocytopenia, immune thrombocytopenia, disseminated intravascular

coagulation and vasculitis. Respondent noted LO would require aggressive intervention and ordered a diagnostic work up and laboratory tests, but did not order steroids to treat her while awaiting the laboratory results. At 11:00 p.m. LO's conditioned worsened. A third on call hematologist from Respondent's group transferred LO to the intensive care unit without evaluating her. LO received a variety of transfusions. On November 13, 1998 at 2:15 a.m. LO had a seizure and at 5:00 a.m. she suffered cardiac arrest and died.

7. When a patient presents with low platelets and hemolytic anemia the standard of care requires a physician to adequately assess the patient, to promptly order laboratory tests and to administer steroids while awaiting laboratory results.

8. Respondent deviated from the standard of care because he did not immediately conduct a history and physical examination, did not promptly order laboratory tests and did not administer steroids to LO while awaiting her laboratory results.

9. Respondent's delay in treatment contributed to LO's death.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public") and A.R.S. § 32-1401 (27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failure to adequately assess a patient with low platelets and hemolytic anemia, for failure to promptly order laboratory tests and for failure to initiate treatment.

2. This Order is the final disposition of case number MD-05-0504C.

DATED AND EFFECTIVE this 13th day of April, 2007.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C.MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of April, 2007 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 13th day of April, 2007 to:

Joseph R. Volk, M.D.
Address of Record

_____
Investigational Review